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Reimbursement Bulletin

2023 Medicare Final Payment Rule Summary for Radiation Therapy

Includes conversion factor update passed through legislation December 2023.

The Center for Medicare and Medicaid Services (CMS) issued the 2023 Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (OPPS) final rules on November 1st, 2022. On December 23, 2022, Congress passed legislation to amend the conversion factor for the physician fee schedule. Below is a summary of how these rules will affect payment policy for radiotherapy services. The finalized payment rates will be effective as of January 1, 2023.

MEDICARE PHYSICIAN FEE SCHEDULE (PFS) FOR PHYSICIANS & FREESTANDING CENTERS

Payment is made under the PFS for professional services furnished by physicians and other practitioners such as nurse practitioners, physician assistants and physical therapists for all sites of service. Freestanding cancer centers and diagnostic testing facilities are also reimbursed under the PFS payment system.

CMS has finalized a series of payment proposals which effectively reduces payments for radiation oncology services by approximately 0-2%. These changes include a decrease in the Conversion Factor and implementation of the second year of the clinical labor update which reduces payments to specialties that use expensive equipment, such as radiation oncology.

Clinical Labor Update
In CY 2022, CMS addressed concerns that clinical labor rates had not been updated since 2002 by the Bureau of Labor Statistics. As a result, CMS finalized a four-year phase in of the clinical labor price input which due to the budget neutral environment shifted payment rates from specialties with higher capital equipment cost input to those with higher, updated labor price inputs. CMS reported that the overall impact of the clinical labor pricing update on radiation oncology was a reduction of 4% on allowed charges, however, cuts are significantly greater for some treatment modalities. The payment rates for radiation oncology services are facing continued cuts in the second year of the phase-in in 2023.

Conversion Factor
The conversion factor, which is the amount used to calculate procedure payment rates from relative value units (RVUs) was finalized to decrease from $34.61 to $33.06 on November 1st when CMS published the physician fee schedule. The decline stems from a statutorily mandated budget neutrality adjustment to account for change in work RVUs. However, through legislative action on December 23, 2023, Congress increased the conversion factor by 2.5%, effectively raising it to $33.89.

Payment for Medicare Telehealth Services Under Section 1834(M) of the Act
CMS maintains a list of services in the MPFS that satisfy the predetermined criteria for a telehealth service. In 2021 during the PHE, CMS added a third category of telehealth services that qualified for payment while the PHE was in effect, but to be reevaluated for clinical benefit and permanent inclusion on the list when the PHE ended. CPT code 77427 for radiation treatment management was granted payment as an interim telehealth service during the PHE, but not formally included within any category for permanent or temporary inclusion. However, the Consolidated Appropriations Act of 2022, provided a provision granting reimbursement for codes considered as a telehealth service on an interim basis 151 days after the end of the PHE. CPT code 77427 is included in this provision.

MEDICARE QUALITY PAYMENT PROGRAM (QPP)

CMS is continuing to move forward toward the MIPS Value Pathways (MVPs) framework which aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. CMS has finalized five additional MVPs, including an "Advancing Cancer Care" MVP.

CMS is not proposing any changes to the weightings of the current reporting categories:

1. Quality performance category: 30%
2. Cost performance category: 30%
3. Promoting Interoperability performance category: 25%
4. Improvement Activities performance category: 15%

Analysis of 2022 Per Course Radiotherapy Reimbursement compared to 2023 Finalized Reimbursement

COMPARISON OF 2022 FINAL TO 2023 FINAL FREESTANDING PER COURSE MEDICARE NATIONAL AVERAGE PAYMENT RATES									
Modality	2022 Final Professional Per Course Payment Rate	2022 Final Technical Per Course Payment Rate	2022 Final Global Per Course Payment Rate	2023 Final Professional Per Course Payment Rate	2023 Final Technical Per Course Payment Rate	2023 Final Global Per Course Payment Ratet	Professional Percent Change	Technical Percent Change	Global Percent Change
2D (10 Fractions)	$1,088	$3,597	$4,685	$1,085	$3,515	$4,601	0%	-2%	-2%
3D w IGRT (25 Fractions)	$2,649	$9,114	$11,763	$2,652	$8,931	$11,583	0%	-2%	-2%
3D w/o IGRT (25 Fractions)	$2,215	$8,285	$10,501	$2,212	$8,098	$10,310	0%	-2%	-2%
IMRT (30 Fractions)	$3,601	$15,893	$19,494	$3,591	$15,573	$19,164	0%	-2%	-2%
SRS	$1,428	$2,093	$3,521	$1,424	$2,066	$3,490	0%	-1%	-1%
SBRT (3 Fractions)	$1,647	$4,340	$5,987	$1,643	$4,283	$5,926	0%	-1%	-1%
SBRT (5 Fractions)	$1,647	$6,286	$7,933	$1,643	$6,181	$7,824	0%	-2%	-1%
APBI HDR	$3,004	$6,988	$9,992	$3,009	$6,998	$10,007	0%	0%	0%
GYN Tandem & Ovoid HDR	$2,269	$3,322	$5,590	$2,265	$3,342	$5,607	0%	1%	0%
Skin HDR (2CM Lesion)	$676	$1,280	$1,956	$672	$1,277	$1,949	-1%	0%	0%

Conversion Factor(CF) used to calculate the PFS facility professional only payment rates is $34.61 for CY 2022 and $33.89 for CY 2023. Number of fractions assumed for 3D, IMRT, SRS, SBRT and Proton courses of care are in line with assumptions made by the Advisory Board in years past. 2D and HDR courses codes as per education from billing and coding seminars.

MEDICARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) RULE

For CY 2023, CMS finalized an increase to overall payment rates by a factor of 3.8%. This increase is based on the hospital inpatient market basket percentage increase of 4.1% for inpatient services paid under the hospital inpatient prospective payment system (IPPS), minus a .3% productivity adjustment.

Section 340B of the Public Health Service Act (340B) allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices. In the CY 2018 OPPS/ASC final rule with comment period, CMS reexamined the appropriateness of paying the average sales price (ASP) plus 6% for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, CMS adopted a policy to pay an adjusted amount — generally ASP minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B Program. CMS continued this policy in CYs 2019 through 2022.

For CY 2023, in light of the Supreme Court's decision in American Hospital Association v. Becerra (No. 20-1114, 2022 WL 2135490), CMS is finalizing a general payment rate of ASP plus 6% for drugs and biologicals acquired through the 340B Program, consistent with our policy for drugs not acquired through the 340B program. As required by statue, CMS is implementing a –3.09% reduction to the payment rates for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023. CMS will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 OPPS/ASC proposed rule. We note that claims for 340B-acquired drugs paid after the district court's September 28, 2022 ruling are paid at the default rate (generally ASP plus 6%).

As finalized, these updates result in a 2.8% increase in payment rates for RT outpatient services.

Software as a Service Payment

Algorithm-driven services that assist practitioners in making clinical assessments can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). These technologies are referred to as software as a service (SaaS). In the CY 2023 OPPS/ASC proposed rule, CMS sought comments on the specific payment approach we might use for these services under the OPPS as SaaS-type technology becomes more widespread. CMS agreed with our recommendation that Software as a Service (SaaS) add-on codes should be paid separate rather than "packaged" with the associated imaging codes.

Comprehensive Ambulatory Payment Classifications (C-APCs)

CMS finalized its proposal to add an additional C-APC, C-APC: 5372 (Level 2 Urology and Related Services), making the total number of APCs 70. CMS did not finalize any policy changes for the existing radiation oncology C-APCs.

Analysis of 2022 Per Course Radiotherapy Reimbursement compared to 2023 Finalized Reimbursement

COMPARISON OF 2022 FINAL TO 2023 FINAL OPPS PER COURSE NATIONAL AVERAGE MEDICARE REIMBURSEMENT			
Modality	2022 Final Per Course Payment Rate	2023 Final Per Course Payment Rate	Percent Change
2D (10 Fractions)	$4,708	$4,944	5.0%
3D (25 Fractions)	$11,170	$11,746	5.2%
IMRT (30 Fractions)	$19,633	$20,287	3.3%
SRS (Comprehensive APC)	$9,708	$9,523	-1.9%
SBRT (3 Fractions)	$8,886	$8,999	1.3%
SBRT (5 Fractions)	$12,428	$12,534	0.8%
Proton (25 Fractions)	$36,254	$36,418	0.5%
Prostate HDR1 (3 Fractions)	$14,543	$15,235	4.8%
GYN Tandem & Ovoid HDR (3 Fractions)	$14,536	$14,912	2.6%
Skin HDR (10 Fractions)	$8,470	$8,651	2.1%

Intended Use Summary

Varian Medical Systems' linear accelerators are intended to provide stereotactic radiosurgery and precision radiotherapy for lesions, tumors, and conditions anywhere in the body where radiation treatment is indicated.

Safety Statement

Radiation treatments may cause side effects that can vary depending on the part of the body being treated. The most frequent ones are typically temporary and may include, but are not limited to, irritation to the respiratory, digestive, urinary or reproductive systems, fatigue, nausea, skin irritation, and hair loss. In some patients, they can be severe. Treatment sessions may vary in complexity and time. Radiation treatment is not appropriate for all cancers.

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